



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

SOUTH TEXAS HEALTH SYSTEM  
3255 W PIONEER PARKWAY  
ARLINGTON TX 76013

#### **Respondent Name**

CITY OF MCALLEN

#### **Carrier's Austin Representative Box**

Box Number 01

#### **MFDR Tracking Number**

M4-11-3065-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "We originally billed for this date of service on 7/02/2010, which was the day that we received the carrier information from the employer... We feel that the submission on 7/14/2010 validates the fact that they did received [sic] this claim timely well within the 95 day rule! We submitted this claim well within the 95 day deadline from the date that we were given the correct carrier information and we feel this claim should be accepted by the carrier and processed for payment release."

**Amount in Dispute:** \$15,881.34

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "The dispute in this case is centered around whether the medical bills for the dates of service were timely submitted within 95 days...In this case, Provider has submitted no evidence that the records were sent certified mail. However, the Provider does allege that the bills were faxed to the Carrier and submitted a fax cover sheet in an effort to prove timely submission. Notwithstanding that there is no evidence as to what documents were allegedly faxed to the Carrier, the documents that were faxed were sent to a number not affiliated with the Carrier. Interestingly, the correct fax number is documented in writing on the cover sheet under the transmission information; however, the number documented in the 'heading' of the fax is incorrect as is the number in the transmission information which shows where the fax was sent to. Therefore, the fax cover sheet is insufficient to show timely submission. Lastly, the attempt at submitting the bills electronically failed, as insufficient information was given in order to process the bill electronically; therefore, the bills were not accepted by electronic submission. Provider's Position Statement attempts to outline numerous reasons as to why the bills may not have been timely submitted, including that they did not have the correct claim file information...A review of the system notes shows that at least by 7/1/10, the Provider had the adjuster's name, the correct address for submitting the bill and the correct claim number for this claim..."

**Response Submitted by:** Parker & Associates, LLC, 7600 Chevy Chase Dr., Suite 350, Austin, TX 78752

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2010 To June 18, 2010	Inpatient Hospital Surgical Services	\$15,881.34	\$15,881.34

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
7. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
8. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
  - (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
9. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 143 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
10. The services in dispute were reduced/denied by the respondent with the following reason code:

Explanation of benefits dated October 14, 2010

  - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.

### **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Were the services in dispute timely submitted to the carrier?
3. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
4. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
5. Is the requestor entitled to additional reimbursement for the disputed services?

## **Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided.” Review of the submitted documentation finds that the requestor has supported that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with the injured employee’s group health insurance carrier. The submitted documentation supports that the provider was notified of the erroneous submission on July 2, 2010. Therefore, the requestor’s submitted documentation sufficiently supports Texas Labor Code §408.0272 applies to the services in dispute.
2. Texas Labor Code §408.0272(c) states that “Notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider’s right to reimbursement for that claim if the provider fails to submit the claim to the correct workers’ compensation insurance carrier within 95 days after the date the provider is notified of the provider’s erroneous submission of the claim.” Review of an explanation of benefits, a copy of which was submitted by both parties, finds notation “**Carrier Rcvd Date:** 10/05/2010” which sufficiently supports that the respondent *received* the medical bill for the services in dispute on October 5, 2010. The Division has established above that the requestor was notified of its erroneous submission of the medical bill for the services in dispute on July 2, 2010, and the EOB’s “**Carrier Rcvd Date**” sufficiently supports that October 5, 2010 is the received date. 28 Texas Administrative Code §102.4(h) states, in pertinent part, that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: ... *the date it was received minus five days*...” The Division concludes that the requestor in this medical fee dispute has timely filed the medical bills as the documentation found sufficiently supports that the requestor submitted the medical bill for the service in dispute within 95 days after July 2, 2010. The respondent’s denial reasons are not supported. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.
3. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
4. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
5. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 511 is \$11,105.83. This amount multiplied by 143% is \$15,881.34. The total maximum allowable reimbursement (MAR) is therefore \$15,881.34, this amount is recommended for payment.

## **Conclusion**

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$15,881.34.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$15,881.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ February 28, 2012 Date
_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ February 28, 2012 Date

## ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**